

Expert Advisory Committee
Tuesday July 31, 2012
8:00am – Healthcentric Advisors
Meeting Minutes

Attendees: John Fleig, Lou Giancola, Joan Kwiatkowski, Elizabeth Lange, Jane Hayward, Kathryn Shanley, Ted Almon, Monica Neronha, Jay Raiola, Bill Delmage, Craig Syata.

- I. Call to Order – Dan Meuse called the meeting to order and welcomed the members. He advised that since we last met, the Supreme Court has issued the decision on the ACA, and the Exchange Director has been named – Christine Ferguson. Today we are going to speak in greater depth on the Small Business Health Options Program (SHOP), diving one level deeper than we had last spring when we last covered this topic.
- II. Jon Kingsdale, Wakely Consulting Group, presented on SHOP. Slides available on the website and upon request.
Questions/Comments/Concerns
 - a. Lou Giancola: The purpose is to try to create greater competition to obviously drive price down and give small business employers and employees more options?
 - i. John Kingsdale: There are two primary rationales, and folks may give them different ways, but one is the idea of choice letting them chose what suits them best, and because it is complicated, Joe's Gas station or Millie's café are unlikely to have to deal with employees mills etc. Or the employees may be several different carriers etc, and one bill may come from the shop exchange to the employer, making It much more feasible to offer. Some employers, be out of the middle, give them dollars and let them chose. The other is that when the employer picks one plan, they are sort of going to find something, for their employees or their spouse, as opposed to picking the plan that's best for each of their employees. This creates a market for carriers to compete on those terms. It is about encouraging competition at the level people subscribed.
 - ii. Ted Almon: It isn't just about completion, but also about the underlying cost of the insurance. Once you aggregate different level plans up at the exchange level, then it starts to balance out.
 - b. Lou Giancola: I guess the other thing is that I don't understand in our state, perhaps if it is insurance regulation, doesn't it then regulate this?
 - i. John Kingsdale: There are some things that regulation can help, but some points where regulation may be hesitant.

Applying the regulation to the hold market is a lot more difficult than being more prescriptive than the choices.

- ii. Lou Giancola: Doesn't that run counter to Ted's point.
- iii. John Kingsdale: Yes, but I will say I disagree a bit with his comments.
- iv. Ted Almon: I'm just not convinced yet.
- c. Monica Neronha: I think you suggested that, if we assume the SHOP builds all four of these models, an employer can then let an employee choose more than one of those? J
 - i. Kathryn Shanley: No, an employer chooses one and the employee falls in through that.
 - ii. Monica Neronha: Ok, I think I just misunderstood.
 - iii. Monica Neronha: What information would you need, or how would you go about making that choice, when it comes to selecting the model for your employees. To employers I would say how are going to make that choice?
 - iv. Ted Almon: Mark Deion spoke to that yesterday, and without numbers in the boxes it is hard.
 - v. Jay Raiola: It is a multi-faceted question and response. Population you are consulting with, in the network out of the network, what can you do with tiered network, what is the age of your population, what are the risks, do you introduce HSA – it is a 10 point 15 point analysis before spreadsheets can be put together.
 - vi. John Kingsdale: An employer may say they do like a Health Savings Account, and move forward with that. Another may say I really ant, or my spouse really wants something else – suggest a silver benchmark. Then I may buy up, someone eels may buy up, others may buy down.
- d. Lou Giancola: I have concerns that you are building in costs for the provider, so the more information you have to collect.
 - i. Ted Almon: We talked about this yesterday at the stakeholder. I believe you have to take the copays and deductibles out of that transaction. The insurer the exchange and the subscriber have an existing relationship,
 - ii. William Delmage: To your point, as an employer you are in charge of all your bad debt exposure. As soon as you move that back to the carrier or the exchange, you are asking that possibly the exchange has the right to shut that person off.
- e. Ted Almon: you have a tendency to keep dividing this conversation into pieces instead of taking it in the whole
 - i. John Kingsdale: we don't have to wrestle this one to the ground here because if you're going to do this it's probably market-wide.
- f. Kathryn Shanley: Broker commissions

- i. John Kingsdale: this is a decision for the Exchange. One model would be the exchange takes existing commission levels that have been developed today and takes the premium money out before remitting to carriers on same fee schedule they have now. Or, the carriers get the full payment and pay the brokers out of that. The challenge is that brokers working with the exchange will have to service all carriers that are in the exchange and I'm not sure how many carriers don't relate to the 2.1 health plans in RI – but in some states there are many more plans and most brokers don't have appointments with every single one. I
 - ii. Kathryn Shanley: if a small employer didn't use a broker, they'd still pay the same premium whether they use the broker or not.
 - iii. John Kingsdale: could be the same, by regulation or law allow commissions to be on top of premiums, on top of premiums – like VT. That's a pretty disruptive model, however – more so that the Exchange deducting the fee for the broker and paying it directly.
 - iv. Kathryn Shanley: Would that mean you would have to have standard commissions?
 - v. John Kingsdale: Probably, yes. The exchange is going to help facilitate the exchange by appointment not the broker.
- g. Elizabeth Lange: As a provider in this room I would love to shift the focus off the us for the patient in the cost department, but...
 - i. Ted Almon: Much more for a big business like the exchange or the insurer. Still paying copays, still have skin in the game.
 - ii. Elizabeth Lange: Unfortunately when people have to pay something for the point of service they have more respect for that service. So I am slightly hesitant to say that unfortunately that payment does give us all some skin in the game at the time of service.
- h. William Delmage: What is the brake out, if you know, between uncompensated care, or bad debt?
 - i. Craig Syata: \$30 million. \$160million uncompensated care.
 - ii. John Fleig: The more administrative burden you put on the exchange, and the debt collection, it is still owed to someone.
 - iii. Ted Almon: The system wide administrative burden is too fragmented.
 - iv. John Fleig: I disagree.
- i. Dan Meuse: While this is a fascinating policy discussion, this would be the same regardless of which model and we do need to get into a deeper conversation about the models today.
 - i. Lou Giancola: The overall point s that I think when I see these options what do we have to go through, and then will we get paid what we have to get paid, and what is the expense. I think

we do need to have a better conversation with patients about the value of care.

- ii. Dan Meuse: Good point, and how does a consumer go from not having insurance to having insurance. It is easy to get into the conversation of what is it like when they have insurance, and how those can be structured when they have a way to look at it. Less administrative burden to everyone in the system. For the purpose of today's discussion, to getting employees from no insurance to insurance, or from one model to another, then the impact that these models will have on the cost and complexity to the system, that is the kind of information I was hoping to provide to elicit feedback on the models themselves.
- iii. Jay Raiola: I agree with you on the complexity – because of transparency, you have a 25 year old who wonders why I have to pay 600 per month for a \$5 co-pay and a deductible. I want a plan that will allow me to self-insure that risk, until I am 40, save the money, and then when I really need it, I can apply it. It is just what we have to deal with moving forward
- iv. Elizabeth Lange: The problem is that I feel your clients are the ones who recognize that money needs to be saved for that deductible. You have to pay one-way or the other.
- j. Dan Meuse: These impacts are market wide, impacts of premium across the small group.
- k. Ted Almon: You are still talking about rating every group?
 - i. John Kingsdale: It is rating every group based on their census.
 - ii. Ted Almon: Do you think that rating groups as an activity adds value?
 - iii. John Kingsdale: Yes it adds value in that the carrier can get the appropriate amount of money for that group. RI could decide there is one community rate, and the variance would be just counting up the number of employees, and RI could legislate that everyone would be in SHOP. Then have an aggregation of the bodies in the exchange. Until that happens, Wakely will not model that. It is a level of hyperbole that doesn't jive with where we are now.
 - iv. Ted Almon: I understand. Rating groups to me seems to be a waste of time. John Kingsdale: That would be an argument for the legislature.
- l. Lou Giancola: Was your point that the 14 were the same for everyone in that age group?
- m. Dan Meuse: Know, the 1404 is that there are three families that have specific age criteria's, and each of them actually has a different rate, but that is not how it is perceived. Each family has the same rate in the perception of the employers. Rates will be different but that is not how they are perceived in a common rate scenario. If a different

employer had the same plan, three families with the same age criteria, these numbers should be the same.

- n. John Kingsdale: It's adjusted community rating.
- o. Jay Raiola: 4:1 going to 3:1 in RI.
- p. John Fleig: There is flat out composite rating?
 - i. John Kingsdale: This rating is all done in the back office, and then it is spit out as a composite.
 - ii. John Fleig: Are you thinking in the SHOP it would be done the same way?
 - iii. John Kingsdale: No, let's proceed to the next slide.
 - iv. John Fleig: After seeing this, this is the adjustment made just on the employees selection of the plan value, but to get to the rate is the SHOP still taking the whole group as that whole? I'm struggling with the difference of how it is rating inside and outside.
 - v. John Kingsdale: That is where the benchmark plan comes in. The employer would pick a benchmark plan and pick his or her contribution based on that. They do not know what the employee will select. For the employer, what is most important is they made a contribution based on a benchmark plan. They employer doesn't know though what the employee will pick. So when you go to the list invoice from the exchange, the employer knows what he is going to pay, but doesn't know what their employees will have to pay.
- q. Dan Meuse: If you have a 30 yr old male and a 62 yr old male, in our current system the elder gentlemen would be paying 50 and the younger 100. If we flatten that out they are both paying 250.
 - i. Ted Almon: Right, the easier bc it would be simpler.
 - ii. John Fleig: Right but its more complicated than that – as the carriers need to level out as their rates are different.
- r. Deb Faulkner: Part of the reason for having adjusted community rating, so that if say Tufts gets all the young people, and BCBS gets all the elder population, their rates are appropriate. Right now, young people get a much lower rate than old people, so if you move to community rating, the penalized group are the younger people.
 - i. Ted Almon: But most of them are in a group anyways, so it would be ameliorated.
 - ii. Deb Faulkner: Right but if as a group they see a large increase, then most will say, well forget it.
 - iii. Ted Almon: But it's a mandatory system, so that will work.
 - iv. John Fleig: Small groups do not have a penalty. All small groups under 50 can say they will no longer offer coverage and there is no penalty there.
 - v. Ted Almon: They will then have an individual mandate.
 - vi. Jay Raiola: If you have a 25 yr old that is X amount for that person and then add in the rate, where is the reconfiguration of

what that single person owes on the subsidy? I think they are coming up with the specific ways that these have to be rated. The problem that some of the models have is, if I bring a 10 person group, but they want the multi issue model, how does it work all fragmented – how is that rated? Not a problem if they all stay with the same carrier and multiple plans.

- vii. John Kingsdale: So we are developing and looking at models to do that, so you do take account of age and benefit level.
- s. Elizabeth Lange: Another issue then is whether or not we are going to have enough providers. The primary care workforce is an issue in this state. We can work very diligently to see everyone, we do need to push on both sense.
 - i. Ted Almon: That is important. But the system that we have today allows us to compensate.
- t. John Fleig: It confuses me, on the SHOP exchange, the employer will set a contribution on something, but y rates are different than another carriers rate – will you have to display the rates for every carrier so the employee knows every point?
 - i. Jay Raiola: That is at the proposal level – if my client wants to see that, then yes.
 - ii. John Fleig: But how is the SHOP itself going to display all these variables.
 - iii. Dan Meuse: The employee will see when they go to the SHOP, what is my cost for each of the plans.
 - iv. John Kingsdale: this is about the employee whose age doesn't change, just a different carrier.
 - v. Dan Meuse: We expect that the SHOP will have an engine so it will know what group that employee is part of, what that age is, and the rating associated with that employee for each of the plan. The SHOP can then calculate the premium, and then there is essentially an engine behind that, how do we display what that employee's monthly premium cost is. We are investigating to see who would implement.
 - vi. William Delmage: In that example, have 12 different options, the concept is the same, it is just expanded.
 - vii. Jay Raiola: And looking at gross premium not net premium. The broker delivers the gross premiums, so then the employer can present to his/her people and they can explain.
 - viii. John Fleig: That is good if they have a broker, just checking if they just go to the Exchange.
 - ix. Dan Meuse: An Employee goes to the SHOP, see what the out of pockets are, every employee is going to be able to go, putting the name and information, and the SHOP will say here are the choices based on the options presented from Employer and your age, rating etc.

- u. John Fleig: The chart you showed, where you said behind the scenes it's a list, then it's aggregated and....
- v. John Kingsdale: It is important to distinguish two types of decisions. When the employer levels out two types of decisions. The employee picks a different plan than the benchmark plan. The bill that I showed you, with the red marks, reflects that the employees have chosen some different options. The employer has already fixed his cost.

III. Wrap Up:

- a. John Fleig: If I were a consumer I would want these choices. If you said would you want all this choice if it you knew it would substantially add to the cost of coverage?
 - i. Dan Meuse: That is why we provided as much information as possible to assist in soliciting feedback from you on these comments.
- b. Kathryn Shanley: Is there something between the two models?
 - i. John Kingsdale: The price is a function of a small employer contribution just from bronze. One way to deal with that is that choice can only be one tier up.
 - ii. Kathryn Shanley: You don't have to have platinum?
 - iii. Dan Meuse: Federal legislation says you only HAVE to offer gold and silver.
- c. Lou Giancola: I think it may be beneficial to lay the goals out again, and then see if these models would or can speak to those goals.
 - i. Dan Meuse: The items we see as impactful when it comes to goals were simplicity, affordability and the ability to make an impact on health care costs. As John mentioned, we are required to do the One Plan model, not required to do anything else. As a state if we want to make it more attractive to employers, and to their brokers and options. Do we want to have a totally new way of doing things? Maybe yes, maybe not. From our perspective, it is less likely to see simply from the upper left hand model competition on price, but a desire to brand. On the silver there will not be a whole lot of different in cost but you will see a real branding effort, and a play for populations and customers based on issuer. Now the one-issuer multi tier is where you will see the consumers making choices that would benefit them more based on what their benefit needs are. The benchmark is united silver, and you can choose any other untied metal tier, then you will see movement.
- d. John Kingsdale: At least if you talk to insurers, they are afraid that the opposite will happen, they are afraid the brand will be commoditized, and the choices will only be made on very small price different.
 - i. John Fleig: And I would say even in the one plan model, there will be changes in price.

- ii. John Kingsdale: we looked at 2010 data and there will as range of 12% data.
 - iii. Lou Giancola: It comes down to a philosophical view of how you standardize care, and market it. We do need to keep long term goals in mind – quality, cost, value. Most value for the consumer and the government.
- IV. Public Comment: No additional comment put forward at this time
- V. Adjourn.